IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

August 9, 2006

FILE COPY

M. Kathi Brink, Administrator
Ashley Manor - 8th Street, Ashley Manor, LLC
940 W 8th South
Mountain Home, ID 83647

License #: RC-759

Dear Ms. Brink:

On June 21, 2006, a complaint investigation survey was conducted at Ashley Manor - 8th Street, Ashley Manor, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Patrick Hendrickson, R.N., Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

for

PATRICK HENDRICKSON, R.N.
Team Leader
Health Facility Surveyor
Residential Care Assisted Living Program

PH/slc

c: Jamie Simpson, BS, QRMP, MBA, Supervisor, Residential Community Care Program

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July 3, 2006

FILE COPY

M. Kathi Brink, Administrator
Ashley Manor - 8th Street, Ashley Manor, LLC
940 W 8th South
Mountain Home, ID 83647

Dear Ms. Brink:

On June 21, 2006, a complaint investigation survey was conducted at Ashley Manor - 8th Street, Ashley Manor, LLC. The survey was conducted by Patrick Hendrickson, R.N. and Frutoso Gonzalez, R.N. This report outlines the findings of our investigation.

Complaint # ID00001506

Allegation #1: The facility was not providing activities for the residents.

Findings: Based on observation, interview and record review it was determined the facility did provide activities for residents.

Review of the facility's activity board on June 21, 2006 documented the facility provided scheduled activities.

Review of the facility's complaint log on June 21, 2006 revealed no documented complaints the facility was not providing activities.

On June 21, 2006 at 1:50 p.m., the residents' were observed to be playing cards and doing art work with staff.

On June 21, 2006 at 2:15 p.m., the house manager stated that activities are provided to residents and she is in the process of implementing more activities for the residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complain investigation conducted on June 21, 2006.

Allegation #2: The interior of the facility was dirty.

Findings: Based on observation and interview it was determined the facility was clean.

On June 21, 2006 at 12:15 p.m., a tour of the facility revealed the resident sleeping rooms to be clean and free of odors. The common area was clean and free of clutter.

On June 21, 2006 at 1:00 p.m., the house manger stated she was not aware of an instance where the resident rooms were not clean or had strong foul odors.

On June 21, 2006 at 2:30 p.m., the regional director stated he was not aware of an instance where the resident rooms were not clean or had strong foul odors.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complain investigation conducted on June 21, 2006.

Allegation #3: Meal potions were extremely small.

Findings: Based on observation, interview and record review it was determined that meals were adequately proportioned.

Review of the facility's menus on June 21, 2006 documented the facility's menus had been review and signed by a registered dietitian.

Review of the facility's complaint log on June 21, 2006 revealed no documented complaints the facility's meals were extremely small.

On June 21, 2006 at 12:30 p.m., lunch was observed to consist of shrimp casserole, cantaloupe and peas. Two residents asked for seconds and their request was fulfilled. Other residents left the dining room with leftovers on their plate.

On June 21, 2006 at 1:30 p.m., a caregiver stated that residents had not complained about small servings and seconds were offered to residents.

On June 21, 2006 at 1:40 p.m., the house manager stated that menus were approved by a registered dietitian and the facility has had no complaints about residents being served small proportions.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complain investigation conducted on June 21, 2006.

Allegation #4: Male residents were left unshaven.

Findings: Based on observation, interview and record review it was determined that male resident's were left unshaven.

On June 21, 2006 at 12:30 p.m., three male residents were observed to be unshaven.

On June 21, 2006 at 1:30, p.m., an employee stated that of the three residents, one shaves himself and the other two residents needed assistance from caregivers to shave them. She further stated the two resident's often refused to be shaved by caregivers.

Review of an random resident's record on June 21, 2006 revealed a Negotiated Service Agreement (NSA) dated June 17, 2006 that documented the resident needed extensive assistance with grooming and personal hygiene. Further it documented the resident did have a history of refusing cares.

Review of the resident's progress notes on June 21, 2006 revealed that staff were not documenting when the resident refused his cares.

On June 21, 2006 at 1:40 p.m., the house manager stated that residents were unshaved and the random resident often refused cares. She confirmed that staff were not documenting when residents refused cares.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.04 for not documenting when residents refuse care. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: Female residents hair was uncombed, and residents smell of urine and had residue of food over their faces and clothing.

Findings: Based on observation, and interview it was determined that a female resident's hair was combed and residents did not smell of urine or had food residue on their faces or clothing.

Review of the facility's complaint log on June 21, 2006 revealed no documented complaints that a female resident's hair was uncombed or residents smelled of urine or residents had residue of food over their faces and clothing.

On June 21, 2006 at 12:30 p.m., a female resident was observed to have her hair combed. Further all residents were not observed to have food residue on their faces or clothing. Residents also did not smell of urine.

June 21, 2006 at 1:30 p.m., an employee stated that residents are toileted every two hours or as needed and all activities of daily living (ADL's) are provided in the morning and as needed.

On June 21, 2006 at 1:40 p.m., the house manager stated that that resident is toileted every two hours or as needed and all ADL's are provided in the morning and as needed. Further she stated she has had no complaints that a female resident's hair was not combed or resident's smelled of urine or there was food residue on residents' faces or clothing.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 21, 2006.

Allegation #6: Residents are not taken to the dining room and assisted to eat. On May 18, 2006 a identified resident did not get lunch or dinner as staff failed to see that she was assisted to the dining room.

Findings: Based on observation, interview and record review it was determined residents were assisted to the dining room and assisted to eat. It could not be determined that on May 18, 2006 the identified resident did not get lunch or dinner as staff failed to see that she was assisted to the dining room.

Review of the facility's admission discharge register on June 21, 2006 revealed the identified resident had been transferred from the facility on June 10, 2006 therefore she could not be interviewed.

Review of the identified resident's closed record on June 21, 2006 revealed a Negotiated Service Agreement (NSA) dated May 30, 2006. The facility documented the resident required her food to be cut up, otherwise she was independent with eating.

Review of the resident's record on June 21, 2006 revealed no documented evidence the resident had not eaten on May 18, 2006.

On June 21, 2006 at 12:15 p.m., six residents were seated at the dining room table eating their meal. Two caregivers were available to assist residents as needed.

On June 21, 2006 at 12:30 p.m., a caregiver was observed assisting a resident to the sofa in the common area after he had completed his meal. Three residents were observed walking independently in the common area after they had completed their meal.

On June 21, 2006 at 2:10 p.m., the house manger stated she was not an employee of the facility at the time the identified resident was at the facility. She said she was not aware of an instance since she had been hired that a resident was not assisted to the dining room for meals if they required assistance.

On June 21, 2006 at 2:30 p.m., the regional director stated he was not aware of an instance where residents were not assisted to the dining room table if they required assistance.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complain investigation conducted on June 21, 2006.

Allegation #7: On May 22, 2006 a identified resident was found to be soaked with urine at 9:00 am. She was not showered until May 23, 2006.

Findings: Based on interview and record review it could not be determined that on May 22, 2006 the identified resident was found soaked with urine at 9:00 a.m. and she had not been showered until May 23, 2006.

Review of the facility admission discharge register on June 21, 2006 revealed the identified resident had been transferred from the facility on June 10, 2006, therefore she could not be interviewed.

Review of the identified resident's closed record on June 21, 2006 revealed a Negotiated Service Agreement (NSA) dated May 30, 2006. The facility documented the resident wore attends and required assistance to change the attends.

Further review of the record revealed no documented evidence the resident had been found soaked in urine on May 22, 2006 and that she was not showered until May 23, 2006.

On June 21, 2006 at 1:10 p.m., a caregiver stated she was not an employee of the facility at the time the identified resident was at the facility. She said she was not aware of an instance since she had been hired that a resident was left soaked in urine. She said she assisted residents with toileting at least every two hours if they required assistance with toileting.

On June 21, 2006 at 2:10 p.m., the house manger stated she was not an employee of the facility at the time the identified resident was at the facility. She said she was not aware of an instance since she had been hired that a resident was left soaked in urine.

On June 21, 2006 at 2:30 p.m., the regional director stated he was not aware of an instance where residents were left soaked in urine.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complain investigation conducted on June 21, 2006.

Allegation #8: Residents were not assisted by staff with their glasses and dentures.

Findings: Based on observation, interview and record review it was determined that one identified resident was assisted with his glasses and dentures. However, it could not be determined a second identified resident had not been assisted with her glasses or dentures.

Review of the facility's admission discharge register on June 21, 2006 revealed the second identified resident had been transferred from the facility on June 10, 2006, therefore she could not be interviewed.

Review of the facility's complaint log on June 21, 2006 revealed no documented complaints that residents were not assisted with their glasses and dentures.

Review of the first identified resident's record on June 21, 2006 revealed a Negotiated Service Agreement (NSA) dated June 17, 2006. The facility documented the resident wore glasses and that staff were to assist the resident with his dentures.

On June 21, 2006 at 12:30, p.m., the first identified resident was observed to have his glasses and dentures on.

Review of the second identified resident's record on June 21, 2006 revealed a NSA dated May 30, 2006. The facility did not document the resident could wash and grooming independently with only verbal

cues. There was no documented evidence the resident required assistance with her glasses or dentures.

On June 21, 2006 at 1:30 p.m., a caregiver stated she was not an employee of the facility at the time the second identified resident was at the facility. She said the first identified resident took his glasses off, however caregivers often remind him to place them back on. She stated the resident always had his dentures in place during the day. She said she was not aware of an instance since she had been hired that a resident was left soaked in urine.

On June 21, 2006 at 1:40 p.m., the house manger stated she was not an employee of the facility at the time the second identified resident was at the facility. She said she was not aware of an instance since she had been hired where residents were not assisted with their glasses or dentures if they required assistance.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 21, 2006.

Allegation #9: Medications were left with the residents and staff do not watch them take the medications.

Findings: Based on observation and interview it was determined that medications were left with the residents and caregivers do not watch them take the medications.

On June 21, 2006 at 12:10, p.m., a resident had a soufflé cup containing medications and eye drops at his side in the dinning room. The caregiver was not present and watching him ingest the medications or administering his eye drops.

June 21, 2006 at 12:15, p.m., an employee stated she had placed the residents medications on the table and walked away to answer the door.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.01.f for not observing resident's taking their medications. The facility was required to submit evidence of resolution within 30 days.

Complaint # ID00001428

Allegation #1: The facility put the resident's personal money in the facility's account and did not open an account for the resident.

Findings #1: Based on interview and record review it was determined the resident was her own payee and never gave her funds to the facility.

Review of the facility admission and discharge register on June 21, 2006 revealed the identified resident was discharged from the facility on May 17, 2006; therefore she could not be interviewed.

Review of the resident's closed record on June 21, 2006 revealed she was a client of the Department.

Further review of the resident's record revealed a uniform assessment instrument dated April 7, 2006 that documented she was her own payee.

On June 21, 2006 at 3:00 p.m., the regional director stated the resident was her own payee. He said the resident kept her own funds.

Conclusion #1: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 21, 2006.

Allegation #2: The facility did not give the resident her money that was left over from paying rent.

Findings #2: Based on interview and record review it was determined the resident was her own payee and would pay rent from her own funds.

Review of the facility admission and discharge register on June 21, 2006 revealed the identified resident was discharged from the facility on May 17, 2006; therefore she could not be interviewed.

Review of the resident's closed record on June 21, 2006 revealed she was a client of the Department.

Further review of the resident's record revealed a uniform assessment instrument dated April 7, 2006 that documented she was her own payee.

Review of the facility's financial records for the resident on June 22, 2006 revealed the resident was her own payee. The record contained billing statements issued to the resident for payment of rent.

On June 21, 2006 at 3:00 p.m., the regional director stated the resident was her own payee. He said the resident kept her own funds and would pay the facility for rent.

Conclusion #2: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 21, 2006.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

PATRICK HENDRICKSON, R.N.
Team Leader
Health Facility Surveyor
Residential Community Care Program

c: Virginia Loper, R.N., Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Ashley Manor 8th Street	940 West 8th South	587-0144
Administrator	**City**	**ZIP Code**
Keith Hetzler	Mountain Home	83647
Survey Team Leader	**Survey Type**	**Survey Date**
Frutoso Gonzalez RN	Complaint investigation	6-22-06

NON-CORE ISSUES

ITEM #	RULE #	DESCRIPTION	DATE RESOLVED
1	16.03.22.310.01.f	Residents were not observed taking their medications. Medication was left by resident at the table.	6-23-06
2	16.03.22.711.04	The facility did not document when the resident refused care.	6-23-06

Response Required Date	Signature of Facility Representative
7-22-06	X [signature]

BFS-686 9/04